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Fresh row over prostate screening

Professor's admission challenges Australia's reverence for medical tests

In 2001 Michael Wilkes and Gavin Yamey, then editors of *the Western Journal of Medicine*, argued in the *San Francisco Chronicle* that there was no good evidence to screen healthy men for prostate cancer. Their article provoked an enormous backlash and they were subject to some particularly vicious lobbying and character assassination. They were said to be promoting "geriatricide," and efforts were made to have them sacked (*BMJ* 2002;324:431).

In Australia in recent weeks, it has been the turn of Professor Alan Coates, chief executive of the Cancer Council Australia, the nation's peak cancer control policy body, to be on the receiving end. Professor Coates had featured in a lengthy report in the *Australian Financial Review* in February, where he declared that he would not choose to have a prostate specific antigen (PSA) test. He said, "The test may find things that didn't need to be found or it may find things when it is too late to fix them. The supposition is that there is a group in between where it finds something early enough to make a real difference, but there is no proof that such a window of opportunity exists."

The *Sydney Morning Herald* called Professor Coates "the apostate professor" whose actions will have confused thousands of men. A federal politician described his statement as "public policy vandalism." He added that it "must be exposed for what it is—contempt for men and their families," which had "torpedoed" a planned public awareness campaign by causing a sponsor to withdraw. Several prominent urologists and advocates for widespread use of the test called for Professor Coates's resignation. Prostate cancer survivors who had been tested expressed their dismay.

Australian urologists are markedly divided on prostate testing. Neither the Urological Society of Australia nor the Australian Prostate Cancer Collaboration support population screening, joining all Australian cancer councils, the US Preventive Services Task Force, and the UK Health Care Evaluation Unit in this position.

This episode has raised challenging communication questions for people in cancer control asked by a journalist to disclose their own actions. With widespread reservations about the wisdom of PSA testing, it is likely that many highly informed cancer officials like Professor Coates would elect not to be tested. Journalists understandably feel this is newsworthy.

Professor Coates's critics have called him irresponsible for declaring his personal decision. But as lying is indefensible, and dodging such a question as inappropriately personal would effectively mean "no," Coates could hardly have answered differently.

The torrent of abuse and ill informed accusations that were unleashed say much about the Australian community's unconditional reverence for medical tests and the fertile ground this creates for those promoting them. Test advocates have skilfully matched the availability of the PSA test with deeply sacrosanct values about the right to know and being "fully informed." Those taking the considered view that it is often wiser to leave well alone are forced to argue for the virtues of remaining ignorant.

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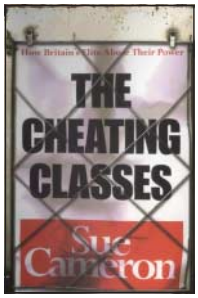
The Cheating Classes: How Britain's Elite Abuse their Power

Sue Cameron



Simon & Schuster, £17.99, pp 259
ISBN 0 684 85130 X

Rating: ★★★★

Frank Cunningham was an 18 year old mechanic in Manchester when he crushed his left leg while motorcross riding. Doctors *x* rayed the bone, confirmed that there had been a break, put the leg in plaster, and sent Frank home. It would take time to mend, they said, but there was nothing to worry about. Several months and many operations later, Frank had to have his leg amputated just below the knee.

What had gone wrong? Sue Cameron claims that Frank was a victim of the cheating classes, those who are among the most privileged members of society, such as doctors, lawyers, bankers, and politicians. Cameron says that few of these people think of themselves as cheats, but nearly every day some of them inflict injustices, great and small, on ordinary men and women.

In Frank's case, a clot had formed after the fracture, cutting off the blood supply to his lower leg. But when Frank had complained of a cold, consuming pain, Cameron reports that a doctor had told him, "It's October. I'm not surprised your toes are cold with the weather like it is today." Days passed and complications set in.

What follows is a disturbing tale of one man against the medical, legal, and bureaucratic establishment as Frank pursues a negligence claim. Eventually, after losing at the first hearing and failing to find a solicitor to take it further, Frank is forced to argue the case himself in the Court of Appeal.

In this eye opening and passionately argued book, Cameron claims that in Britain today there is an ever widening gap between those who have influence and those who do not. Stories like Frank's, therefore, are becoming increasingly common, she says, as more and more people feel excluded from decisions that affect their lives. These are people "whose freedoms are being curtailed, whose demands for decent treatment are being ignored and who find it almost impossible to get redress when they are steamrollered by the big battalions."

Cameron presents eight tales of people who have fallen foul of the cheating classes—their lives often ruined—ending with a call to arms: "Do not be intimidated. That is just what the spin doctors, the rip-off merchants, the unrepresentative elite, the cheating classes in all their guises want."

And what happened to Frank? He won his appeal, but he is still embroiled in legal battles over medical negligence—on behalf of others, not himself.

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Items reviewed are rated on a 4 star scale (4=excellent)

The Deadly Truth: A History of Disease in America

Gerald N Grob

Harvard University Press, $35/£23.50, pp 349
ISBN 0 674 00881 2

Rating: ★★★

At a recent bioethical meeting, Beat Sitter-Liver from the Swiss Academy of Humanities and Social Sciences said that the concept of finitude (a term borrowed from the philosopher Martin Heidegger, meaning the limits of human existence) was virtually non-existent in the United States. For example, Americans seem to think that the possibilities of medicine are unlimited. Gerald Grob's history of disease in the United States echoes this assumption. He writes, "In our modern Western culture we have grown accustomed to the belief that all things are possible and that humans can completely control their destiny." But such faith "is at best harmless and at worst a dangerous utopian illusion," he adds.

Grob, who teaches medical history at Rutgers University in New Jersey, calls his book "a product of nearly three decades of teaching and research." This claim is substantiated by abundant references and meticulously researched statistics on life expectancy, morbidity, and mortality dating from before the arrival of Columbus to the present day.

The focus is on infectious diseases. Mortality patterns among indigenous people before Columbus seem to differ significantly from those found in Europe and Asia. There were no catastrophic epidemics but people were more susceptible to malnutrition and injuries. The discovery of the Americas in 1492 had tragic consequences. Grob says, "The European conquest … had relatively little to do with military prowess or superior technology; it was largely the result of the ravages of disease." As a result of imported infections such as measles, smallpox, plague, and typhus, by 1617 the Amerindian population of La Florida (a region that included the entire south east of the present United States) was perhaps 5% of the total alive a century earlier. English settlers decreased the number of native North Americans through the introduction of liquor.

In the 18th century American colonies had lower morbidity and mortality rates than densely populated European capitals. But by the end of the century the situation began to change as epidemics of measles, malaria, and "throat distemper" (the 18th century term for diphtheria) were recorded in New England. Acute and chronic infections were the major causes of death, whereas the impact of chronic degenerative illnesses was insignificant "because of the youthful nature of American society," where the median age was about 16.

Contrary to the popular belief that health and income are directly related, the rise in the standard of living in 19th century United States was accompanied by increases in morbidity and mortality. This is explained by the spread of endemic infectious diseases (tuberculosis in particular) in overcrowded and unhygienic urban environments. For example, almost a quarter of all deaths in New York City in 1804 are thought to have been caused by tuberculosis and other pulmonary disorders.

During the wars that America fought in the 19th century more men perished from infections than were killed in battle. For example, nearly two thirds of 600 000 deaths during the Civil War were from disease.

The death rate from infections fell by 600% between 1850 and 1920. But Grob doubts that this dramatic decline in mortality might be attributed to advances in medical science. He concludes that strictly medical therapies did not play a significant part in changing disease patterns (when chronic degenerative diseases began to replace acute infections). Antibiotics and vaccines were introduced only after 1940.

The leading cause of mortality in the United States today is heart disease (in 1998 it accounted for 31% of all deaths). The author criticises the risk factor theory as an explanation for the rise of chronic heart disease since 1900 and mentions recent theories that some infections may be responsible.

It is obvious that Americans are living longer and healthier lives than a century ago but Grob says that "the precise reasons for the changes in mortality and morbidity rates (and therefore life expectancy) remained murky."

The central theme of this thought provoking and somewhat pessimistic book is our inability to predict the consequences of our actions: "Confidence in our ability to control the world should be tempered by a wise scepticism and recognition of our limitations." A lesson to bear in mind in more than just medical matters.

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WEBSITE OF THE WEEK

Multidrug resistant tuberculosis Bleeding, purging, bed rest, horseback riding, the mountains, the seashore, cod liver oil, castor oil, chaulmoogra oil, phrenic nerve interruption, thoracoplasty, and pneumothorax—these are just a few of the mostly useless treatments offered for "consumption" until the discovery of antituberculous therapy in the 1940s and 1950s.

The 1960s saw the development of the DOTS strategy involving directly observed administration of short course first line chemotherapy (p 574). By the early 1990s, the world had a global programme for tuberculosis control, based on DOTS. Visit www.who.int/gtb/publications/ttgnp/index.htm for a comprehensive outline of this programme.

But by 1997, the World Health Organization and the International Union Against Tuberculosis and Lung Disease found resistance to first line TB drugs in every single country they examined (www.who.int/gtb/publications/PDF/tb97_229.pdf). Multidrug resistant tuberculosis—dubbed "the new white plague" (www.ama-assn.org/sci-pubs/msjama/articles/vol_284/no_21/jms00037.htm) and "the ticking TB time bomb" (www.tballiance.org/2_1_2_MDR_TB.asp)—had arrived.

What can be done to defuse the time bomb? What can we offer countries such as Russia, Estonia, Latvia, the Ivory Coast, and the Dominican Republic, the "'hot zones' of ongoing transmission" of multidrug resistant tuberculosis (http://bmj.com/cgi/content/full/317/7159/671)? Searching for answers on the internet, I kept coming across one solution offered by WHO and its partners: the DOTS-plus strategy. This advocates a rational approach to use of second line drugs with or without drug susceptibility testing (www.who.int/gtb/policyrd/DOTSplus.htm). Yet a paper in this week's *BMJ* warns that implementation of DOTS-plus might divert resources away from DOTS, decreasing the effectiveness of DOTS—in this scenario, more patients would die from tuberculosis under DOTS-plus than under DOTS alone (p 574).

Although the paper argues that "the proposed widespread implementation of DOTS-plus has been controversial," it is hard to find much evidence of this controversy online. The arguments I could find centred around issues of whether drug susceptibility testing and second line drugs are cost effective and sustainable. One physician on the front line—in the Dominican Republic—writes: "We must always attempt to treat and cure the individual patient but initiating a 'DOTS-plus' strategy at a national level is, at present, a dream; it risks diverting our limited resources and causing epidemiological havoc. We should not awaken one day only to realize that our dream has become a microbiological nightmare" (http://bmj.com/cgi/eletters/317/7159/671#830).

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PERSONAL VIEW

The doctor will text you now: is there a role for the mobile telephone in health care?

Over the past year I have started to use the mobile phone, particularly SMS (Short Message Service) text messaging facilities, in routine clinical care. I have previously written about the virtues of direct email contact with patients and also the concept of cyberclinics in routine clinical practice (*BMJ* 2000;320:59). But whereas internet and email access remain relatively limited, the mobile phone and text messaging are widely used.

Text messaging is an easy and convenient way of allowing patients to keep in touch. For example, after clinics and investigations the usual scenario is that patients wait (and worry) for several weeks before they get their results and information about any follow up action or advice. I have now slashed this waiting time to only a few days by allowing patients to text message me three to four days after their investigations. (I do not have to take patients' mobile telephone numbers, but they take a patient information card, which carries mine.) I then text the patients back with their results and any subsequent course of action.

Similarly, I encourage patients to text me to report whether or not any treatment or intervention—for example, corticosteroid injections into joints or soft tissues—has been successful. If patients do not report the expected benefit, then I can offer further advice or, if necessary, arrange an earlier appointment. I have been able to discharge a sizeable proportion of patients following text message reporting.

Patients can also text a codeword to a given telephone number. Within seconds, a return message can provide results, further advice, appointment times, or other specific messages. Security features ensure patient confidentiality. SMS text messages are written, unambiguous records of important data and are free of the kind of transcription errors that can occur while dictating results or other information over the telephone. This automated service needs careful evaluation, but it has the potential to help a large number of patients.

I feel that this service provides round the clock security and assurance to my patients. If text messages arrive at inconvenient times—for example, while patients (or doctors) are driving, when they are in a meeting, or at night—they are held until patients are ready; there is no need for urgent or immediate action. Such text messaging facilities beat any other avenue of contact, such as the postal service, the telephone, and email, for sheer portability and convenience.

Patients can use text messaging facilities to contact me urgently if they have particular worries, and I can return their call on the telephone or using email to offer advice or to make an earlier appointment for further assessment in the clinic. This means that waiting times can be reduced to a fraction of what happens in usual practice, and patients are more reassured and proactive in their treatment and contact with doctors.

We are now exploring sending patients text alerts about a week or 10 days before their next clinic appointment. This will enable patients to say whether or not they can keep the appointment. If they cannot, then we can make the vacant slots available to other patients. Non-attendance in clinics is still notoriously high in many centres, including our own. Text or email alerts could eventually help stop this waste of limited NHS resources.

> Patients are more reassured and proactive

We are also looking at the possibility of sending text message alerts to remind patients of blood and urine monitoring tests if they are on disease modifying drugs such as methotrexate or myocrisin. Despite reminders when patients are seen at the clinics, they often forget these monitoring tests, with, in some instances, disastrous consequences (including deaths). Text messaging alerts can also be useful to remind women to take their contraceptive pills or people with asthma to use their inhalers. We believe that text message or email reminders of this kind will help to reduce many of the problems associated with clinic attendance and chronic disease management.

We have developed software programs that allow text messages to be sent to mobile telephone numbers via any standard PC, messages to be copied to more than one individual, and even letters to be generated for routine post or via email to other interested parties such as general practitioners. Furthermore, instead of typing any advice or results to patients afresh each time, we are developing standard message options to suit most circumstances. This will help to reduce the time taken to type each message manually.

The ability to use a mobile phone to take and send pictures may open up other opportunities for mobiles in clinical care—for example, to send photographs of skin rashes, joint swellings, or even parts injured in car crashes or other emergencies. As yet, however, this remains to be explored.

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The author would like to acknowledge the contributions of James Burrell, Marek Isalski, Joan Kay, Andrea Myerscough, and Julie Broadbent

SOUNDINGS

The king and I

For many of my colleagues, junior or senior, a winter break means a spot of skiing. You can tell when a trip is in the offing. They look thoughtful and you catch them doing quadriceps exercises. Afterwards you notice their facial tans and sense of relief at surviving intact. Or occasionally you hear them praising the efficiency of Alpine casualty departments.

Why don't I join in? I pretend it is inherent mistrust of quick-release bindings, or unwillingness to dress like a fluorescent Teletubby, but the real reason is that skiers are readily classifiable. There are "black run bombers," there are the merely competent, and then there are those who spend most of their time upside down in a snowdrift. I know which I am.

Nevertheless the urge to migrate in winter is infectious and is no longer restricted to the rich. Most patients over a certain age seem to head for the sun when the New Year holiday is over. My wife and I, stern Scots who believe that getting warm in January would be cheating, stick to European cities.

Madrid, due south but 635 metres above sea level, was sufficiently bracing last month to keep our consciences clear but not cold enough to stop Andean buskers playing drums and pan pipes. The city's cultural diversity included the national ballet providing its own accompaniment with handclaps and voices, and *Harry Potter and the Chamber of Secrets* dubbed into Spanish.

Luxury is visiting an art gallery knowing you can return tomorrow. Some paintings take your breath away when you see them for real, however familiar the image. Picasso's *Guernica* is no longer behind glass but still has two guards. It produces a visceral revulsion against war in general and air raids in particular. Some might want to throw acid. I wanted to send a postcard of it to Downing Street.

Outside the Palacio Real, we came across a crowd. Over in the courtyard were guards on horseback, men in suits, watchful police, and dozens of white-gloved motorcyclists. We waited. Headlights appeared and then an accelerating line of Mercedes. Fleetingly, there was the king of Spain, and the queen's hand waving out of a just-open car window. Strange, isn't it, that an unplanned glimpse should prove as memorable as a roomful of Goyas.

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